CHAPTER 14

LEGAL IMPLICATIONS IN MEDICAL CARE

There are few aspects of medical administration or treatment that do not have some legal implications. Every time a patient comes into contact with a facility or its staff members, either directly or indirectly, formally or informally, the potential for legal entanglements exists.

Although the law has become more and more involved in the operation of hospitals, the exercise of common sense combined with a knowledge of those situations that require special care will protect the hospital and its staff from most difficulties.

A brief description of the situations that regularly arise and have legal consequences and the policy and instructions which apply in those situations follow. It is important to keep in mind that the law is an inexact science, subject to widely varying fact situations. The information in this chapter cannot substitute for the advice of an attorney. Hospital staff members are encouraged to consult with the hospital or area Judge Advocate General Corps (JAG) officers on issues with which they are uncomfortable.

CONSENT REQUIREMENTS FOR MEDICAL TREATMENT

With limited exceptions, every person has the right not to be touched without him or her having first given permission. This right to be touched only when and in the manner authorized is the foundation of the requirement that consent must be obtained before medical treatment is initiated. Failure to obtain consent may result in the health care provider being responsible for an assault and battery upon the patient.

INFORMED CONSENT

While the term "consent" in the medical setting refers to a patient's expressed or implied agreement to submit to an examination or treatment, the doctrine of "informed consent" requires that the health care provider give the patient all the information necessary for a knowledgeable decision on the proposed procedure. When courts say that a patient's consent must be informed, they are saying that a patient's agreement to a medical procedure must be made with full awareness of the consequences of the agreement. If there is no such awareness, there has been no lawful consent.

The duty to inform and explain rests with the provider. This responsibility cannot be delegated.

The provider must describe the proposed procedure in lay terms so that the patient understands the nature of what is proposed. The risks of the treatment must be explained. If there are any alternative medical options, they should be disclosed and discussed.

For common medical procedures that are considered to be simple and essentially risk free, a provider is not required to explain consequences that are generally understood to be remote. A determination of what is simple and common should be made from the perspective of appropriate medical standards. Where the harm that could result is serious or the risk of harm is high, the duty to disclose is greater.

Methods should be developed within each hospital department to acquaint patients with the benefits, risks, and alternatives to the proposed treatment. In some departments, prepared pamphlets or information sheets maybe desirable. In others, oral communication may be the best method. Some states, i.e., Texas have laws that are very specific about what is required.

EMERGENCY SITUATIONS

Consent prior to treatment is not necessary when treatment appears to be immediately required to prevent deterioration or aggravation of a patient's condition, especially in life threatening situations, and it is not possible to obtain a valid consent from the patient or a person authorized to consent for the patient.

The existence and scope of the emergency should be adequately documented.

WHO MAY CONSENT

The determination of who has authority to consent to medical treatment is based on an evaluation of the competency of the patient. If competent, usually the patient alone has the authority to consent. Competency refers to the ability to understand the nature and consequences of one's decisions. In the absence of contrary evidence, it may be assumed that the patient presenting for treatment is competent. If the patient is incompetent, either by reason of statutory incompetence (i.e., a minor) or by reason of a physical or mental impairment, then the inquiry must turn to who, if anyone, has the legal capacity to consent on behalf of the patient. Parents and guardians will usually have the authority to consent for their minor child or children. In many states, though not all, a husband or wife may give consent for an incompetent spouse. It is the law of the state in which the hospital is located that controls the question of "substitute consent."

FORMS OF CONSENT

Consent for medical treatment should be obtained through an open discussion between the provider and patient during which the patient expressly agrees to the procedure. The consent should then be documented by having the patient sign any appropriate forms and by the provider noting any important details of the discussion in the medical record.

In certain limited circumstances, the consent of an individual to simple medical treatment may be implied from the circumstances. Implied consent arises by reasonable inference from the conduct of the patient or the individual authorized to consent for the patient. Reliance on this form of consent is strongly discouraged except in the most routine, risk free examinations and procedures.

WITNESSES TO CONSENT

Any competent adult may witness the patient's consent. It is preferable that the witness be a staff member of the hospital who is not participating in the procedure. It is not advisable for a relative of the patient to act as a witness.

DURATION OF CONSENT

A consent is valid as long as there has been no material change in circumstances between the date that consent was given and the date of the procedure. It is desirable that a new consent be obtained if there is a significant time lapse or if the patient has been discharged and readmitted due to postponement of the procedure.

INCIDENT REPORTS

When an event occurs that harms an individual, illustrates a potential for harm, or evidences serious dissatisfaction by patients, visitors, or staff, then a risk management incident has taken place. Examples of such episodes could include the following:

- A patient's family helps him or her out of bed despite directions to the contrary by staff members. The patient falls and is injured

- Excessive silver nitrate is put into the eyes of a newborn, impairing vision

- The mother of a child complains about the care that has been given to her child and informs a staff member that she is going to talk to her lawyer about what has happened

When a member of the staff becomes aware of an incident, he or she has a responsibility to make the hospital command aware of the situation. The mechanism for doing this is the incident report system. Incident reports are designed to promptly document all circumstances surrounding an event, to alert the commanding officer, quality assurance coordinator, and other involved administrators and clinicians of a potential liability situation and, in a broader sense, to establish an information base on which to monitor and evaluate the number and types of incidents that take place in the facility.

Because incident reports, by their very nature, contain a great deal of information that would be of interest to persons who are filing claims or lawsuits against the Navy for alleged substandard medical care, and because the law recognizes the need for hospitals to have a reliable means of discovering and correcting problems, most states have enacted laws that make incident reports confidential. In other words, a person cannot obtain a copy of an incident report to help in

their legal action against the hospital. However, incident reports can lose their "protected" status if they are misused or mishandled. It is important, therefore, that you treat these reports like other confidential documents. You must strictly limit the number of copies made and the distribution of the reports. Do not include the report in the patient's treatment record. The report should be limited to the facts and must not contain conclusions. And finally, the report should be addressed and forwarded directly to the quality assurance coordinator of the hospital.

RELEASE OF MEDICAL INFORMATION

Two federal statutes, the Privacy Act and the Freedom of Information Act (FOIA), combine to establish the criteria for collecting, maintaining, and releasing medical treatment records.

FREEDOM OF INFORMATION ACT

The Freedom of Information Act governs the disclosure of documents compiled and maintained by government agencies. A written request for Department of the Navy records that explicitly or implicitly refers to FOIA must be responded to in accordance with the provisions of the Act. The Department of the Navy will make available to any person all documents, not otherwise exempt, provided the requester reasonably describes the records sought and promises to pay for reasonable search and photocopy costs. Each naval activity is responsible for developing procedures for ensuring the prompt handling; retrieval, and review of requested records. The official having responsibility for the records has 10 working days to respond to the requester.

A naval record will be withheld only when it is exempt from disclosure under FOIA. One basis for exempting a record from disclosure applies to personnel, medical, and similar files, the release of which would constitute a clearly unwarranted invasion of personal privacy. This concern over clearly unwarranted privacy intrusion is reflected in the provisions of the Privacy Act.

PRIVACY ACT

The public's concern over the inner workings and functioning of the government was the impetus that gave rise to the FOIA. However, it became obvious that a balance had to be made between the public's right to know and other significant rights and interests. One of these competing interests was protection of an individual's personal right to privacy. In response to this need, the Privacy Act of 1974 was enacted. The stated purpose of the Act is to establish safeguards concerning the right to privacy by regulating the collection, maintenance, use, and dissemination of personal information by federal agencies.

The Privacy Act requires federal agencies to:

1. Permit an individual to know what records pertaining to him or her are collected, maintained, used, or disseminated by the agency
2. Permit an individual to prevent records pertaining to him or her obtained by the agency for a particular purpose from being used or made available for another purpose without his or her consent
3. Permit an individual to gain access to information pertaining to him or her in federal agency records, to have a copy made for all or any portion thereof, and to correct or amend such records
4. Collect, maintain, use, or disseminate any record of identifiable personal information in a manner that ensures that such action is for a necessary and lawful purpose, that the information is current and accurate, and that adequate safeguards are provided to prevent misuse of such information
5. Permit exemptions from the requirements of the Act only in those cases where there is specific statutory authority to do so
6. Be subject to civil suit for any damages that occur as a result of willful or intentional violation of any individual's rights under the Act.

In addition, any officer or employee of an agency who willfully violates certain provisions of the Act is subject to criminal prosecution, with penalties ranging to a fine of $5,000.

Under the Act's provisions concerning disclosure of information, there are several circumstances under which naval treatment records and their contents can be disclosed. Included are disclosures to employees of the Department of the Navy who have a need to know the information. Also included are disclosures to a person under compelling circumstances affecting health or safety, pursuant to a court order, and to another government agency for civil or criminal law enforcement activities. Circumstances under which the release of medical

information is appropriate are discussed in the section concerning law enforcement personnel.

MEDICAL CONDITIONS AND LAW ENFORCEMENT PERSONNEL

Some medical conditions by their very occurrence will result in involvement of law enforcement personnel. Individuals who are injured while committing a criminal offense, who are victims of abuse, neglect, or assault, who are impaired or injured as a result of drug abuse, or who are injured as a result of a traffic accident will often be the subject of an official investigation. Many times the investigators will want to question the patient or the health care providers treating the patient. Often the medical records of the patient will be requested by authorities. Occasionally, officials will want to take the patient into custody.

Under the Posse Comitatus Act, a Federal statute enacted in 1956 (18 U.S.C. 1385), it is unlawful for the U.S. military to be used to enforce or assist in the enforcement of federal or state civil laws. There are many exceptions to the Act, but the issue for health care personnel is settled by asking: "Is the medical procedure being done on this patient for a legitimate medical reason or is it only being performed to assist civil law enforcement?" Provided there is a reasonable medical justification for the procedure, then the results of the procedure may be shared with civil law enforcement officials under the circumstances discussed below.

Cooperation with law enforcement officials, to the extent possible, is required. Provided there are no medical contraindications, patients who are either suspected of having committed an offense, or who are presumed victims of criminal activity, will be made available to speak with investigators. As discussed previously, access to medical treatment records is governed by the Privacy Act and FOIA. Generally, records of patients may be made available to U.S. Navy investigators once they have established a need to know the information. This determination will usually be made by the hospital staff judge advocate or patient affairs officer. Other Department of Defense, federal, state, or local law enforcement officers may have access to treatment records if access is necessary as a part of a criminal investigation and there is no unwarranted violation of the privacy rights of the individual involved. Similarly, local health and social service departments may be provided information from the record. The same guidelines that apply to access to treatment records apply to staff members discussing with investigating officers the details of the medical treatment provided to a patient.

DELIVERY OF A PATIENT UNDER WARRANT OF ARREST

No patient may be released from treatment before it is medically reasonable to do so. Once it is determined that the individual can be released without significant risk of harm, the following guidelines regarding release to law enforcement authorities apply.

- Nonactive Duty Patients: When a non active duty patient is released from medical treatment, the facility normally no longer exercises any degree of control and normal legal processes will occur. No official action by hospital personnel is required before local authorities take custody of the released patient. There may be occasions, however, when law enforcement officials should be notified of an imminent release of a patient.

- Active Duty Patients: The commanding officer is authorized to and should deliver personnel to federal law enforcement authorities who display proper credentials and represent to the command that a federal warrant for the arrest of the individual concerned has been issued. There are circumstances in which delivery maybe refused; however, guidance should be sought from a judge advocate of the Navy or Marine Corps when delivery is to be denied.

Normally, it is the responsibility of the permanent command to take custody and control of an active duty member suspected of committing an offense. If the member is an unauthorized absentee and the command to which he or she is assigned is not in the same geographic area as the treatment facility, then release of the patient should be coordinated with the nearest Transient Personnel Unit or Military Prisoner Escort Unit. Close liaison with the member's permanent command should be established as well.

In cases where delivery of an active duty patient is requested by local civil authorities, and the treatment facility is located within the requesting jurisdiction or aboard a ship within the territorial waters of such jurisdiction,

commanding officers are authorized to deliver the patient when a proper warrant is presented, except in certain limited circumstances. A judge advocate of the Navy or Marine Corps should be consulted before delivery, if possible. If the treatment facility is located outside the jurisdiction requesting delivery, only a General Courts-Martial authority (as defined by the *Uniform Code of Military Justice, Manual for Courts-Martial, and Navy Regulations)* is authorized to arrange for delivery of such a patient. Extradition, return agreements, and other prerequisites to delivery will have to be completed.

When disciplinary proceedings involving military offenses are pending, the treatment facility should obtain legal guidance from a judge advocate before delivering a patient to federal, state, or local authorities if reasonably practicable. When the commanding officer considers that extraordinary circumstances exist which indicate that delivery should be denied, then the Judge Advocate General of the Navy must be notified of the circumstances by message or phone.

PRISONER PATIENTS

Prisoner patients fall into three categories of eligible beneficiaries: enemy prisoners of war and other detained personnel, nonmilitary federal prisoners, and military prisoners.

Enemy Prisoners of War and Other Detained Personnel

Enemy prisoners of war and other detained personnel are entitled to all necessary medical and dental care subject to the availability of care and facilities.

Nonmilitary Federal Prisoners

Nonmilitary federal prisoners are authorized only emergency medical care. When such care is being provided, the institution to which the prisoner is sentenced must furnish the security personnel to ensure custody of the prisoner and safety of others in the facility. Upon completion of emergency care, arrangements will be made immediately to transfer these individuals to a nonmilitary treatment facility or for return to the institution to which sentenced.

Military Prisoners

Status of Forces policy is to protect, to the maximum extent possible, the rights of U.S. personnel who may be subject to criminal trial by foreign courts and imprisonment in foreign prisons. Active duty members are generally not separated from the service until they have completed their term of imprisonment and returned to the United States. During this confinement, they will normally remain health care beneficiaries.

Military prisoners (those sentenced under the *Uniform Code of Military Justice)* whose punitive discharges have been executed but whose sentences have not expired are authorized medical and dental care. Individuals on appellate leave, awaiting execution of a punitive discharge, are also entitled to care. Military prisoners whose punitive discharges have been executed and who require hospitalization beyond expiration of their sentence are not eligible for care, but may be hospitalized as civilian humanitarian nonmilitary indigents until disposition can be made to some other facility.

SEXUAL ASSAULT AND RAPE

Sexual assault and rape are criminal offenses, often associated with serious injury. The management of cases involving sexual assault and rape must be a joint medicolegal function. A Sexual Assault Investigation Kit, supplied by the Naval Investigative Service, is used to gather and preserve evidence of the crime. Included in this kit are step-by-step procedures for the examination of the patient as well as a checklist of specimens to be collected.

In order to safeguard and obtain evidence to be used in possible legal proceedings, liaison between the naval treatment facility, military and civil investigative agencies, and state and local service agencies (such as Child and Spouse Protective Services) should be established. It must be kept in mind that medical personnel are not to judge, defend, or prosecute the individuals involved. Every effort must be made to treat the patient with respect and courtesy and to provide appropriate privacy. In dealing with alleged victims of sexual assault, careful attention to psychological factors must be given to lessen the impact of the incident. This is especially important when a minor is involved and the reaction of adults may be more harmful than the actual assault itself. Tactful questioning and the use of appropriate terminology are of extreme importance throughout the history taking and examination.

Child and Spouse Abuse and Neglect: The nature of child and spouse abuse and neglect requires a careful patient history and physical examination to identify or rule out past and present injuries caused by abuse or neglect. The policies and guidelines established by the Navy Family Advocacy Program must be followed. This program is discussed in some detail later in this chapter.

SUBSTANCE ABUSE PREVENTION AND CONTROL

Drug and alcohol abuse is costly in terms of lost work hours and unnecessary administrative and judicial processing and is a critical drawdown on morale and espirit de corps. It undermines the very fiber of professional readiness, safety, discipline, judgement, and loyalty. It is not just the abuser who is affected, but the abuser's shipmates as well. "Zero Tolerance" recognizes that drug and alcohol abuse is incompatible with the maintenance of high standards of performance, military discipline, and readiness and is destructive of Navy efforts to instill pride and professionalism.

Medical personnel become professionally involved in the substance abuse program when called upon to withdraw blood or urine from an individual suspected of drug or alcohol abuse. Few areas cause as much concern and confusion to health care providers as the question of when those bodily fluids can be lawfully extracted.

At the outset a few basic facts must be discussed. First, the health care provider should not undertake a fluid extraction procedure when to do so is medically contraindicated. Second, refusal to perform an extraction in the face of lawful authority could subject the health care provider to charges of obstruction of justice or willful disobedience of an order. Third, the health care provider is not an arbiter of the law. In other words, the admissibility of evidence derived from a blood or urine sample is not a matter for Medical Department personnel to decide. Finally, common sense and cooperation with command and law enforcement officials should be the guideposts in every instance where extraction of bodily fluids is an issue.

The following are the circumstances where withdrawal of blood or urine from active duty military members is authorized.

- Consensual withdrawal. If an individual expressly consents to an extraction of bodily fluids and there is a legitimate reason for extraction, the health care provider may perform the procedure.

- Valid medical purpose. Specimens maybe obtained from an individual for a valid medical examination provided the individual has expressly or implicitly consented to the examination.

- Competency for duty examinations. The competency for duty examination request form (NAVMED 6120/1) contains a block for the submitting authority to request laboratory analysis. See figures 14-1 and 14-2. The following procedure should be used in handling competency for duty requests.

- The command initiating the request should complete items 1 through 12 of the form. The individual submitting the request must have authority to make the request. Normally, this will be a commanding officer, executive officer, or duty officer of the initiating command.

- After proper initiation of the request, the medical officer or other authorized health care provider will complete blocks 13 through 49 on the form.

- If the command has requested laboratory analysis, the patient should first be requested to give written consent to the procedure. If the patient will not give consent but will allow extraction, then the sample should be taken. If the patient refuses consent and will physically resist extraction, then the requesting command should be notified and no extraction attempted unless a search authorization is issued, which is discussed further in the probable cause search and seizure section.

PROBABLE CAUSE SEARCH AND SEIZURE

Under the authority contained in the Military Rules of Evidence, nonconsensual extraction of bodily fluids, including blood and urine, may be made from an individual pursuant to a search warrant or authorization. Further, when there is a

COMPETENCE FOR DUTY EXAMINATION
NAVMED 6120/1 (1-70) S/N 0105-LF-208-3050
(Formerly NAVMED 1430)

INSTRUCTIONS FOR THE USE AND PURPOSE OF THIS FORM ARE CONTAINED IN BUMEDINST 6120.20 SERIES.
THIS FORM SHALL NOT BE USED FOR PROCEDURES PERFORMED FOR CLINICAL OR THERAPY PURPOSES.

DEFINITION OF COMPETENCE FOR DUTY

FOR PERSONS IN THE NAVAL SERVICE: The ability to perform fully the naval duties to which the individual normally would be assigned. (Note: A person who has indulged in intoxicating beverages, narcotics or dangerous drugs to such an extent as to impair sensibly the rational and full exercise of his mental and physical faculties cannot be entrusted with the duties incident to naval service. The fact that the person is in a patient, leave, or liberty status is immaterial to the determination of his competence to perform his naval duties.)

FOR ALL OTHERS: The mental and physical ability to perform fully any task or service which the individual may normally be expected to perform.

INSTRUCTIONS

1. Items 1-12 shall be completed in duplicate by the commanding officer or other proper authority requesting examination.
2. Items 13-49 shall be completed by medical officer conducting examination. Under item 13, History, include information provided by examinee as to ingestion and quantity of alcoholic beverage, narcotic, drug substance, or food, and time taken. Note any evidence of disease or injury (other than the condition promoting this examination) in item 16.
3. When conducting an examination for competence for duty and individual is accused or suspected of an offense, comply with BuMedInst 6120.20 series.
4. All treatment provided at the time of examination shall be entered on form NAVMED 6150/3, Sick Call Treatment Record.

A. REQUEST FOR EXAMINATION

1. TO:	2. DATE	3. TIME *(Hours)*

It is requested that a physical examination be given the following individual to determine competence for duty.

4. NAME *(Last, first, middle)*	5. GRADE OR RATE	6. DUTY STATION

7. REASON FOR REFERRAL

8. SIGNATURE *(Requester)*	9. GRADE OR RATE	10. TITLE
11. NAME OF REQUESTER *(Typewrite or print in ink)*		12. DUTY STATION

B. CLINICAL EXAMINATION

13. HISTORY

14. GENERAL APPEARANCE *(Include appearance of clothing)*	15. MENTAL STATE

16. DISEASES OR INJURIES *(Other than the condition prompting this examination, per inst. 2 above)*

17. TEMPERATURE	18. PULSE *(Rate and character)*
19. BLOOD PRESSURE	
20. FACE *(Flushed, pallid, cyanotic)*	21. TONGUE
	22. BREATH
23. SKIN *(Warm, cool, moist, dry, pale)*	24. SPEECH *(Thick, slurred, ability to repeat words such as Merciful, Pedestrian, Peter Piper)*
25. EYES *(Size of pupils, reaction to light, conjunctivae, etc.)*	

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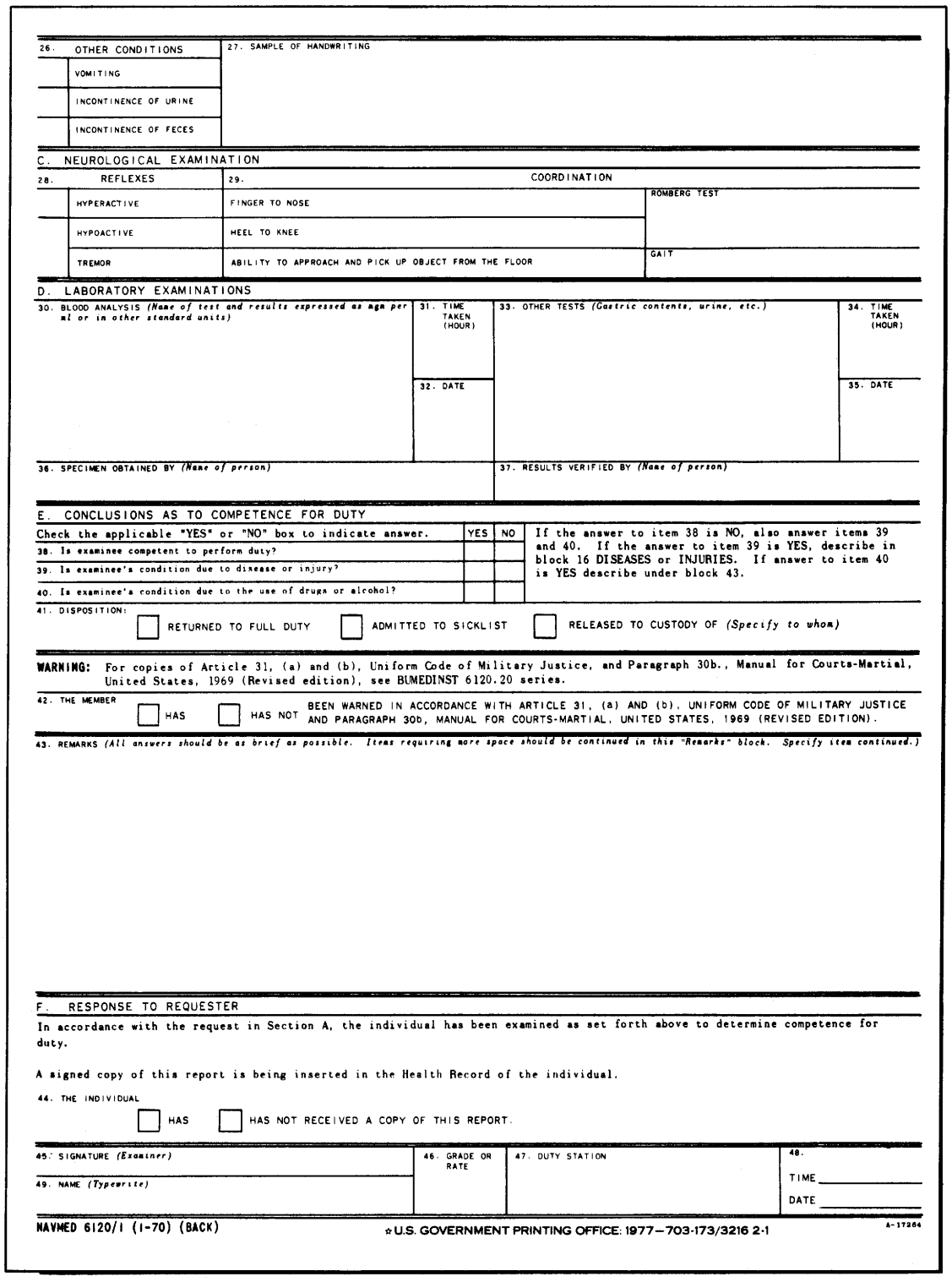
Figure 14-1.—NAVMED 6120/1, Competence for Duty Examination, (Front).



26. OTHER CONDITIONS		27. SAMPLE OF HANDWRITING
	VOMITING	
	INCONTINENCE OF URINE	
	INCONTINENCE OF FECES	

C. NEUROLOGICAL EXAMINATION

28. REFLEXES		29. COORDINATION	
	HYPERACTIVE	FINGER TO NOSE	ROMBERG TEST
	HYPOACTIVE	HEEL TO KNEE	
	TREMOR	ABILITY TO APPROACH AND PICK UP OBJECT FROM THE FLOOR	GAIT

D. LABORATORY EXAMINATIONS

30. BLOOD ANALYSIS *(Name of test and results expressed as mgm per ml or in other standard units)*	31. TIME TAKEN (HOUR)	33. OTHER TESTS *(Gastric contents, urine, etc.)*	34. TIME TAKEN (HOUR)
	32. DATE		35. DATE
36. SPECIMEN OBTAINED BY *(Name of person)*		37. RESULTS VERIFIED BY *(Name of person)*	

E. CONCLUSIONS AS TO COMPETENCE FOR DUTY

Check the applicable "YES" or "NO" box to indicate answer.	YES	NO
38. Is examinee competent to perform duty?		
39. Is examinee's condition due to disease or injury?		
40. Is examinee's condition due to the use of drugs or alcohol?		

If the answer to item 38 is NO, also answer items 39 and 40. If the answer to item 39 is YES, describe in block 16 DISEASES or INJURIES. If answer to item 40 is YES describe under block 43.

41. DISPOSITION:
☐ RETURNED TO FULL DUTY ☐ ADMITTED TO SICKLIST ☐ RELEASED TO CUSTODY OF *(Specify to whom)*

WARNING: For copies of Article 31, (a) and (b), Uniform Code of Military Justice, and Paragraph 30b., Manual for Courts-Martial, United States, 1969 (Revised edition), see BUMEDINST 6120.20 series.

42. THE MEMBER ☐ HAS ☐ HAS NOT BEEN WARNED IN ACCORDANCE WITH ARTICLE 31, (a) AND (b), UNIFORM CODE OF MILITARY JUSTICE AND PARAGRAPH 30b, MANUAL FOR COURTS-MARTIAL, UNITED STATES, 1969 (REVISED EDITION).

43. REMARKS *(All answers should be as brief as possible. Items requiring more space should be continued in this "Remarks" block. Specify item continued.)*

F. RESPONSE TO REQUESTER

In accordance with the request in Section A, the individual has been examined as set forth above to determine competence for duty.

A signed copy of this report is being inserted in the Health Record of the individual.

44. THE INDIVIDUAL ☐ HAS ☐ HAS NOT RECEIVED A COPY OF THIS REPORT.

45. SIGNATURE *(Examiner)*	46. GRADE OR RATE	47. DUTY STATION	48. TIME / DATE
49. NAME *(Typewrite)*			

NAVMED 6120/1 (1-70) (BACK) ☆U.S. GOVERNMENT PRINTING OFFICE: 1977—703-173/3216 2-1 A-17264

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Figure 14-2.—NAVMED 6120/1, Competence for Duty Examination, (Back).

clear indication that evidence of a crime may be found and there is reason to believe that the delay involved in getting a warrant or authorization will result in the destruction of evidence, the nonconsensual extraction may be made without a warrant or authorization. (Such situations are refered to as exigent circumstances.) Involuntary extraction of fluids must be done in a reasonable fashion by a person with appropriate medical qualifications.

The following procedures should be adhered to when a search warrant or authorization for extraction of bodily fluids is present or extraction is ordered on the basis of exigent circumstances.

- The patient should be requested to give written consent to the procedure. If the patient refuses to give consent, then he or she should be clearly advised of the existence of the search warrant or authorization and ordered to submit. If the patient allows extraction, it should then proceed.

- If the patient will physically resist extraction then the command or authority issuing the search document will be immediately contacted to determine whether forcible extraction will be attempted. In reaching this decision, one must consider all factors including, but not limited to the seriousness of the alleged offense; the need for the fluid sample; the level of resistance anticipated; medical contraindications to extraction; and the need for trained law enforcement assistance to ensure the safety of staff and other patients. If for any reason the medical staff and the initiating command do not agree on a course of action then the medical facility commanding officer will be immediately notified.

- Samples drawn pursuant to a search authorization or warrant or under exigent circumstances should be documented and processed using a chain of custody form. Each person taking custody of the form must sign the form before taking custody of the sample. The sample must not be left unattended unless it is placed in a secure location that has extremely limited access (e.g., a safe or locked refrigerator).

PROBABLE CAUSE SEARCH OF CIVILIANS

If law enforcement authorities request extraction of bodily fluids from a nonmilitary person pursuant to a federal, state, or local search warrant, the medical staff should immediately contact the hospital judge advocate or the Naval Legal Service Office for guidance.

FAMILY ADVOCACY PROGRAM

During the early 1970s, increased awareness of child maltreatment prompted the Surgeon General to advocate a program dealing with both the medical and social aspects of the problem. In 1976, the Navy established its Child Advocacy Program to provide protection to dependent children who were abused, neglected, or abandoned. In 1979, the medical program was expanded to include spouse abuse and neglect, sexual assault and rape, and was redesignated as the Family Advocacy Program. At the same time, the Navy and Marine Corps began to develop formal servicewide management of family support programs.

The objective of the Family Advocacy Program is to prevent family maltreatment through information and education to deter illegal actions, and to provide treatment and support for the persons involved.

The Director of Naval Medicine is responsible for providing the resources, professional services, and technical assistance required to support the health care requirements of the program. To carry out these responsibilities, naval hospitals have established local Family Advocacy Programs, appointed Family Advocacy Committees to review management of individual and community problem situations relating to child abuse/neglect, spouse abuse, and sexual assault and rape incidents, and have designated a social worker or senior member of the command as the Family Advocacy Representative (FAR) to manage the local Family Advocacy Program.

POLICIES AND RESPONSIBILITIES

In those cases where the victim of child or spouse abuse is considered to be in real and present danger of death or serious bodily harm, the medical officer shall initiate immediate action to remove the victim from the situation placing them in danger, to provide required medical care, to secure protective custody in the case of child abuse, and to secure and provide shelter care to ensure health, welfare, and safety needs are met.

REMOVAL FROM DANGEROUS SITUATION

The Duty Officer or FAR usually lacks the authority to remove the victim from a dangerous situation against the will of the parent, guardian, or caretaker. If it is determined that such action is necessary, the appropriate law enforcement agency, family/youth court, and state or local protection agency shall be notified and petitioned to remove and escort the victim to an appropriate facility for medical attention or protection services.

EMERGENCY MEDICAL CARE

A detailed medical examination will be conducted on all abuse victims and medical treatment provided, when required. Notify the FAR or Deputy Family Advocacy Representative (DFAR) immediately of all such cases. The FAR or DFAR will notify civilian agencies in accordance with state/local laws. If other than a medical officer renders initial medical treatment, and as a result, a reasonable suspicion that abuse, neglect, or sexual assault results, the immediate assistance of a medical officer shall be requested. In remote or independent settings where a medical officer may not be physically available, guidance shall be obtained by phone, or other expeditious means, and recorded in the patient's health record, and appropriate dispositions or referrals made. An abuse victim may be hospitalized temporarily for protective purposes if alternative placement is not available. The abuse victim should remain hospitalized until such time as satisfactory placement has been arranged. Coordination with a Navy judge advocate or other legal counsel and community child abuse/neglect officials is encouraged in cases in which parental consent to hospitalization is refused.

INTERVENING AUTHORITY

Because abuse incidents may occur in areas of concurrent or inclusive civilian jurisdiction, it is imperative that military and civilian agencies work together to ensure rapid intervention in the interest of abuse victims.

LINE OF DUTY AND MISCONDUCT

In each case in which a member of the naval service incurs an injury that might result in a permanent disability or which results in physical inability to perform duty for a period exceeding 24 hours, a finding concerning line of duty and misconduct must be made. The terms "line of duty," "not in line of duty," and "misconduct" are used in combination to describe the status of an active duty member when a disease or injury is incurred.

It is the responsibility of the commanding officer or officer in charge of the individual at the time of the injury or disease to convene the necessary investigation or to take appropriate action.

If a member of the naval service is injured at a place distant from his or her command and is admitted to a naval hospital, the commanding officer of the naval hospital shall, if no investigation is being made of the incident, promptly report the matter to the area coordinator or designate a subordinate commander who shall take action to ensure that any required investigation is made.

HOW FINDINGS ARE DOCUMENTED

Depending on the extent of injury or disease, the circumstances in which the injury or disease was incurred, and the permanence of resulting disability, line of duty/misconduct determinations are recorded by one of the three following procedures.

- JAG Manual investigation—A fact-finding body must be convened and the commanding officer must make findings concerning misconduct and line of duty in any case that:

  - The injury was incurred under circumstances which suggest that a finding of "misconduct" might result.

  - The injury was incurred under circumstances which suggest that a finding of "not in the line of duty" might result.

  - There is a reasonable chance of permanent disability being involved and the commanding officer considers that the appointment of a fact-finding body is the appropriate means by which to ensure that an adequate official record is made concerning the circumstances surrounding the incident.

● The injured member is in the Naval Reserve or Marine Corps Reserve and the commanding officer considers that the appointment of a fact-finding body is the appropriate means by which to ensure that an adequate official record is made concerning the circumstances surrounding the incident.

● Entry in health or dental record—No fact-finding body needs to be convened and no report needs to be forwarded to the Judge Advocate General concerning misconduct and line of duty when:

● In the opinion of the medical officer (or representative of a medical department) as concurred in by the individual's commanding officer, the injury is not likely to result in a permanent disability and was incurred in line of duty and not as a result of the member's own misconduct.

● Appropriate entries to this effect have been made in the service member's health or dental records (MMD 16-45 and 16-71).

● Injury report, forms, or letter reports

● An injury report form and/or letter report (RCS JAG 5800/19) may be used in any case in which line of duty and misconduct findings are required by section 0805.

● Reports may be made to the Judge Advocate General using NAVJAG Form 5800/15 without a cover letter.

● Any accident reporting form including the Marine Corps Accident and Injury Report (NAVMC 10767), may be used in reporting injuries resulting from motor vehicle accidents. These forms must be forwarded with a letter report.

● The form or letter report that is directed to the Judge Advocate General under this section shall be forwarded via an officer exercising general court-martial jurisdiction, who will cause it to be examined by a judge advocate.

RELATIONSHIP BETWEEN MISCONDUCT AND LINE OF DUTY

An injury cannot be the result of misconduct and be in the line of duty. The three possible combinations of findings are in the line of duty and not due to member's own misconduct; not in the line of duty and not due to member's own misconduct; and not in the line of duty and due to member's own misconduct. In the absence of clear and convincing evidence to the contrary, it is presumed that disease or injury has been incurred in the line of duty. Generally, an injury or disease is not in the line of duty if incurred:

- As a result of such gross negligence as to demonstrate a wanton disregard of the consequence
- While one is absent without leave
- While one is confined awaiting a dishonorable discharge

Other circumstances giving rise to a finding of misconduct are set forth in Chapter VIII of the *Manual of the Judge Advocate General.*

EFFECT OF AN APPROVED FINDING OF MISCONDUCT

A finding of misconduct may result in an extension of enlistment, loss of entitlement to creditable service, forfeiture of pay, loss of disability retirement and severance pay, and loss of certain benefits administrated by the Veteran's Administration.

REFERENCES:

The following sources provide further information and guidance on the topics covered in this chapter.

1. Consent for Medical Treatment
   BUMEDINST 6320.31B

2. Incident Reports
   BUMEDINST 6000.10
   NAVMEDCOMINST 6320.7

3. Freedom of Information Act
   SECNAVINST 5720.42C
   BUMEDINST 6000.10

4. Privacy Act
   SECNAVINST 521 1.5C
   BUMEDINST 6000.10

5. Persons in Military Custody
   BUMEDINST 6320.31B
   BUMEDINST 6320.49A
   SECNAVINST 5820.4E
   SECNAVINST 1640.9 (Series)
   SECNAVINST 1640.6 (Series)

6. Delivery of Patient under Warrant of Arrest
   JAGMAN Chapter XIII

7. Family Advocacy Program/Child Abuse/Spouse Abuse/Sexual Assault/Rape
   BUMEDINST 6320.57
   BUMEDINST 6000.10
   OPNAVINST 1752.xx (pending)

8. Substance Abuse Prevention and Control
   OPNAVINST 5350.4

9. Line of Duty Misconduct
   JAGMAN Chapter VIII
   BUMEDINST 6000.10

10. Probable Cause/Search and Seizure
    Military Rule of Evidence 315

11. Competency for Duty Examination
    BUMEDINST 6120.20A